Department of HUMAN SERVICES

Chronic Condition Health Homes 2020

January, 2020

Contents

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Health Homes Introduction

Executive Summary

Summary description including goals and objectives:

A Health Home focused on members with one chronic condition and the risk of developing another.

The Health Home program enrolls Designated Providers to deliver personalized, coordinated care for individuals meeting program eligibility criteria. In return for the additional Health Home Services to members, the Designated Provider is paid a per member per month (PMPM) payment. Managed Care Organizations (MCOs) serve as the Lead Entity and:

- Develop a network of health homes
- Educate and support providers
- Provide training, technical assistance, expertise and oversight to the Health Homes
- Provide oversight and technical support for HH providers to coordinate with primary care providers
- Provide infrastructure and tools to HH providers
- Provide outcomes tools and measurement protocols to assess effectiveness
- Provide clinical guidelines and other decision support tools
- Provide a repository for member data
- Support providers to share data
- Develop and offer learning activities
- Perform data analysis at the member level and program-wide to inform continuous quality improvement
- Offer Performance Measures Program which may include incentives
- Reimburse providers
- Identify/enroll members

Health Information Technology (HIT) will link services, provide feedback and facilitate communication among team members. Electronic sharing of health data among Lead Entities, behavioral and physical health providers in a HIPAA compliant manner enables tight coordination with the broader physical health delivery system. Online profiles are able to include medical, behavioral and pharmacy history.

The use of HIT is a means of facilitating these processes that include the following components of care:

- Mental health/ behavioral health

- Oral health
- Long-term care
- Chronic disease management
- Recovery services and social health services available in the community
- Behavior modification interventions aimed at supporting health management (e.g., obesity counseling and tobacco cessation, health coaching)
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up

Goals and Objectives are measured using best practice standards.

- Improved care coordination will be noted through chart reviews, claims, and analysis.
- Strengthened community linkages noted through administrative review, chart reviews and claims.
- Strengthened team-based care noted through administrative review.
- Increased integration of primary and behavioral health care noted through administrative review
- Improved health outcomes noted through analysis.
- Improved health status noted through analysis.
- Reduction in hospitalizations noted through analysis.
- Reduction in hospital readmissions noted through analysis.
- Increased access to primary care, with a reduction in inappropriate use of emergency room noted through analysis.
- Improved identification of substance use/abuse and engagement in treatment noted through analysis.
- Reduction in lifestyle-related risk factors noted through analysis.
- Improved experience of care noted through analysis.

The Chronic Condition Health Home Website is located:
https://dhs.iowa.gov/ime/providers/enrollment/healthhome
The Member Health Home Website is located:
https://dhs.iowa.gov/ime/members/medicaid-a-to-z/health-home and provides information to members looking for additional services.

Health Homes Population and Enrollment Criteria

One chronic condition and the risk of developing another
Specify the conditions included:

- Mental Health Condition
- Substance Abuse Disorder
- Asthma
- Diabetes

- Heart Disease
- BMI over 25
- Chronic Pain
- COPD
- Hypertension
- BMI over 85th percentile for pediatric populations

Specify the criteria for at risk of developing another chronic condition:

At risk can be defined as documented family history of a verified heritable condition in a category described above, a diagnosed medical condition with an established comorbidity to a condition in a category described above, or a verified environmental exposure to an agent or condition known to be causative of a condition from a category described above. Providers can follow the guiding principles posted at the department's website http://www.ime.state.ia.us/. The guiding principles use US Preventative Services Task Force (USPSTF) guidelines to identify at risk conditions. All at risk conditions must be documented in the patient's medical record at the time the member is enrolled in the program.

Health Homes Geographic Limitations

Health Home Services will be available statewide.

Enrollment of Participants:

Opt-In
Describe the process used:

A provider presents the qualifying member with the benefits of participating in the Chronic Condition Health Home and the member agrees to opt-in to Health Home services. The State or Lead Entity may also identify members for potential enrollment into a health home. In either situation, the member will always be presented with the choice of providers and with the ability to opt-out at any time. A member cannot be in more than one health home at the same time.

- **The State provides assurance that eligible individuals will be given a free choice of Health Homes providers.**
- **The State provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.**
- **The State provides assurance that hospitals participating under the State Plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need**

treatment in a hospital emergency department to designated Health Homes providers.

- **The State provides assurance that it will have the systems in places of that only one 8 quarter period of enhanced FMAP for each Health Homes enrollee will be claimed. Enhanced FMAP may only be claimed for the first eight quarters after the effective date of a Health Homes State Plan Amendment that makes Health Home Services available to a new population, such as people in a particular geographic area or people with a particular chronic condition.**
- **The State assures that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.**

Health Homes Providers

Designated Providers
Indicate the Health Homes Designated Providers the State includes in its program and the provider qualifications and standards:

- Physicians
- Clinical Practices or Clinical Group Practices
- Rural Health Clinics
- Community Health Centers
- Community Mental Health Centers
- FQHC

Describe the Provider Qualifications and Standards:

Physicians (Designated Practitioner):
The Health Home must have at least one MD/DO. The MD/DO must have an active Iowa license and credentialed.

Nurses:
The Health Home must have nurses to support the Health Home in meeting the provider standards and deliver Health Home Services to qualified members. The Nurse Care Managers must be a Registered Nurse (RN) or a Bachelor of Science in Nursing (BSN) with an active Iowa license.

Health Coaches:
The Health Home must have a trained health coach to support the Health Home in meeting the provider standards and delivering Health Home Services to qualified member. The Health Coach must have passed a competency exam based on Health Coach Training. The Health Coach Training domains include:

- Patient-centered communication that promotes behavior change in a way that improves their quality of care.

- Motivational interviewing brief clinical encounters that tap into the patient's own motivation to change around chronic condition management, wellness, and prevention
- Recognize cues that reveal one's behavior change readiness and assess readiness
- Person-centered goal setting
- Patient engagement to develop patients to be effective self-managers
- Decrease patient/client resistance to their own treatment plan
- Behavior-change theories and the health belief model as a foundation for practice
- Improve health literacy through effective communications strategies
- Provide resources, connections with wrap around supports and education to assist "evidence-based patient choice" decisions
- Pass performance evaluation

Supports for Health Homes Providers
Describe the methods by which the State will support providers of Health Home services in addressing the following components:

1. Provide quality driven, cost effective, culturally appropriate, and person and family-centered Health Home services,
2. Coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines,
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders,
4. Coordinate and provide access to mental health and substance abuse services,
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care,
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families,
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services,
8. Coordinate and provide access to long-term care supports and services,
9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health care related needs and services:
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate:
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic

disease management on individual level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

Description:
The State will support Health Home in achieving the 11 components listed above by designing a program that aligns provider standards and a payment method that ensures quality providers enter the program, that they have a clear understanding of the expectations and that there is an appropriate reimbursement structure to ensure sustainability for the providers.

The state expects providers to grow into the role of a successful Health Home and has built-in requirements that the Lead Entity both train and facilitate best practices among the network of Health Home Providers.

The State facilitates a Health Home Focus Group comprised of IME, MCO, and Health Home personnel to ensure training, communication, and alignment on key policy and operational issues.

The State facilitates a Learning Collaborative where Lead Entities will assist CCHHs to meet the Provider Standards and to participate in quality improvement activities designed to improve outcomes for the members. The Learning Collaborative consists of:

- Monthly collaborative webinar
- Bi-annual face-to-face training
- Individual provider technical assistance that can be provided by telephone or on site
- Quarterly newsletter
- IME Health Home Webpages
- Process improvement for the Health Homes.

The State will develop a program manual to provide clear guidance and expectations to both Lead Entities and Health Homes.

Designated contact information to IME or MCO staff for member enrollment, billing and project management.

Individualized technical assistance in connecting with state Health Information Exchange to report the quality measures.

MCOs are contractually required to provide training, technical assistance, expertise and oversight to health Homes and to perform data analysis at the member level and program-wide to inform continuous quality improvement. The State reviews and approves the MCO's methodologies and continually monitors for compliance.

The Lead Entity is expected to build capacity among the Health Home Providers by meeting the following requirements:

- Identification of providers who meet the standards of participation as a Chronic Condition Health Home (CCHH):
    - Assessment of the CCHH's capacity to provide integrated care
    - Educate and support providers to deliver integrated care
    - Provide oversight, training, and technical support for CCHHs to coordinate integrated care
- Have capacity to provide clinical and care coordination support to Health Home providers, including:
    - Confirmation of screening and identification of members eligible for Health Home Services
    - Provide oversight and support of Health Home providers to develop care plans and identify care management interventions for CCHH members
    - Providing or contracting for care coordination, including face-to-face meetings, as necessary to ensure implementation of care plan and appropriate receipt of services
    - Gathering and sharing member-level information regarding health care utilization, gaps in care, and medications
    - Monitor and intervene for CCHH members who are high need with complex treatment plans
- Have capacity to develop provider information technology infrastructure and provide program tools, including:
    - Providing tools for CCHHs to assess and customize care management based on the physical/behavioral health risk level of recipient
    - Performing data analytics on personal, medical and pharmacy data to identify patterns of care, as well as track, and close gaps in care
    - Providing outcomes tools and measurement protocols to assess Health Home concept effectiveness
    - Provide infrastructure and tools to Health Home Providers to facilitate patient care coordination
    - Providing clinical guidelines and other decision support tools
    - Repository for member data including claims, laboratory, and Continuing Care Document (CCD) data whenever possible; and
    - Support providers to share data including CCD or other data from electronic health records (EHR).
- Have capacity to develop and offer learning activities which will support providers of Health Home services in addressing the following areas:
    - Providing quality driven, cost effective, culturally appropriate, and person and family driven Health Home Services
    - High quality health care services informed by evidence-based clinical practice guidelines
    - Preventive and health promotion services, including prevention of mental illness and substance use disorders
    - Comprehensive care management, care coordination, and transitional care across settings (transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care)

- Chronic disease management, including self-management support to members and their families
- Demonstrating a capacity to use health information technology to link services, facilitate communication among team members and between the Health Home Team and individual and family care givers, and provide feedback to practices, as feasible and appropriate
- Establishing a continuous quality improvement program, and collecting and reporting on data that permits an evaluation of increased coordination of care and chronic disease management on individual level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Homes Services.
A Health Home Practice will serve as a Designated Provider and may include multiple sites when those sites are identified as a single organization or medical group that shares policies and procedures and electronic systems across all of their practice sites.

Each Health Home Practice is registered with the State and provided a state assigned health home provider ID. Health Home Practices may contract with one or more MCOs to deliver services to managed care enrollees. To be enrolled as a Health Home with an MCO, the Health Home must first register with the State.

Practitioners operating within a Health Home Practice agree to adhere to the Health Home Provider Standards.

- Health Home Practices may include but are not limited to primary care practices, Community Mental Health Centers, Federally Qualified Health Centers, and Rural Health Clinics.
- At a minimum, practices must fill the following roles:
  - Designated Practitioner
  - NP/PA
  - Dedicated Care Coordinator
  - Health Coach

The Health Home Practice coordinates, directs, and ensures all clinical data related to the member is maintained within the member's medical records. The use of Health Information Technology (HIT) is the required means of facilitating these processes.

Provider Standards

The State's minimum requirements and expectations for Health Home providers are as follows:
To enroll as a health home practice, Designated Providers must sign an agreement attesting adherence to the below standards:

- Health Home Provider will have demonstrated capacity to address the following components, as outlined in SMDL #10-024.
    - Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services
    - Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines
    - Coordinate and provide access to preventive and health promotion services
    - Coordinate and provide access to mental health and substance abuse services
    - Coordinate and provide access to comprehensive care management, care coordination, and transitional care and medication reconciliation across settings. Transitional care includes appropriate follow-up from inpatient care/PMIC/group care to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care
    - Coordinate and provide access to chronic disease management, including self-management support to individuals and their families;
    - Coordinate and provide access to individual and family supports, including education and referral to community, social support, and recovery and resiliency services
    - Coordinate and provide access to long-term care supports and services
    - Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services, in collaboration with the lead entity or IME
    - Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate

- Recognition/Certification
    - Health Home Providers must adhere to all federal and state laws in regard to Health Home recognition/certification.
    - Comply with standards specified in the Iowa Department of Public Health rules. Those rules will likely require National Committee for Quality Assurance (NCQA) or other national accreditation.
    - Until those rules are final, providers shall meet the following recognition/certification standards:
        - Complete the DHS self-assessment and submit to the State at the time of enrollment in the program and annually
        - Achieve PCMH Recognition/Certification, such as NCQA, other national accreditation, or another program recognized by the State within the first year of operation and maintain.
        - Exception applied for a Health Home past the first year where an application has been submitted and pending ruling. The Health Home must prove application submission status on demand and

the State may terminate health home enrollment if recognition/certification status has not been achieved within 2 years of operation.

- Personal provider for each patient
    - Ensure each patient has an ongoing relationship with a personal provider, physician, nurse practitioner or physician assistant who is trained to provide first contact, continuous and comprehensive care, where both the patient and the provider/care team recognize each other as partners in care. This relationship is initiated by the patient choosing the Health Home.
- Continuity of Care Document (CCD)
    - Update a CCD for all eligible patients, detailing all important aspects of the patients medical needs, treatment plan and medication list. The CCD shall be updated and maintained by the Health Home Provider.
- Whole Person Orientation
    - Provide or take responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life, acute care, chronic care, preventive services, long-term care, and end of life care.
    - Implement a formal screening tool to assess behavioral health (mental health and substance abuse) treatment needs along with physical health care needs.
    - Have evidence of bi-directional and integrated primary care/behavioral health services through use of a contract, memoranda of agreement or other written agreements approved by the State
    - Provide letters of support from at least one area hospital and two area primary care practices that agree to collaborate with the Health Home on care coordination and hospital/ER notification.
- Advocate in the community on behalf of their Health Home members as needed Coordinated/Integrated Care
    - Dedicate a care coordinator, defined as a member of the Health Home Provider, responsible for assisting members with medication adherence, appointments, referral scheduling, tracking follow-up results from referrals, understanding health insurance coverage, reminders, transition of care, wellness education, health support and/or lifestyle modification, and behavior changes
    - Utilize member level information, member profiles, and care coordination plans for high risk individuals
    - Incorporate tools and evidenced-based guidelines designed for identifying care opportunities across the age and diagnostic continuum, integrating clinical practices, and coordinating care with other providers
    - Conduct interventions as indicated based on the member's level of risk
    - Communicate with patient, and authorized family and caregivers in a culturally appropriate manner for the purposes of assessment of care decisions, including the identification of authorized representatives
    - Monitor, arrange, and evaluate appropriate evidence-based and/or evidence-informed preventive services

    - Coordinate or provide:
        - Mental healthcare
        - Oral health
        - Long term care
        - Chronic disease management
        - Recovery services and social health services available in the community
        - Behavior modification interventions aimed at supporting health management (Including but not limited to, obesity counseling, tobacco cessation, and health coaching)
        - Comprehensive transitional care from inpatient to other settings, including appropriate follow-up
    - Assess social, educational, housing, transportation, and vocational needs that may contribute to disease and/or present as barriers to self-management
    - Coordinate with Community-Based Case Managers (CBCM), Case Manager (CM) and Service Coordinators for members that receive Service Coordination activities.
    - Maintain system and written standards/protocols for tracking patient referrals.
- Emphasis on Quality and Safety
    - An ongoing quality improvement plan to address gaps and opportunities for improvement
    - Participate in ongoing process improvement on clinical indicators overall cost effectiveness specified by and reported to the State
    - Demonstrate continuing development of fundamental Health Home functionality through an assessment process to be applied by the State.
    - Have strong, engaged organizational leadership whom are personally committed to and capable of:
        - Leading the practice through the transformation process and sustaining transformed practice
        - Agreeing to participate in learning activities including in person sessions, webinars, and regularly scheduled phone calls
    - Agree to participate in ad hoc or scheduled meetings to plan and discuss implementation of goals and objectives for practice transformation
    - Participate in CMS and State required evaluation activities
    - Submit reports as required by the State (e.g., describe Health Home activities, efforts and progress in implementing Health Home services)
    - Maintain compliance with all of the terms and conditions as an IHH provider or face termination as a provider of IHH services
    - Complete web-based member enrollment, disenrollment, enrollee authorizations for information sharing, and health risk questionnaires for all members
    - Demonstrate use of clinical decision support within the practice workflow.

    - Demonstrate use of a population management tool, (patient registry) and the ability to evaluate results and implement interventions that improve outcomes overtime.
    - Demonstrate evidence of acquisition, installation and adoption of a certified EHR system and establish a plan to meaningfully use health information in accordance with the Federal law.
    - Each Health Home shall implement or support a formal diabetes disease management program. The disease management program shall include:
        - The goal to improve health outcomes using evidence-based guidelines and protocols.
        - A measure for diabetes clinical outcomes that include timeliness, completion, and results of AIC, LDL, microalbumin, and eye examinations for each patient identified with a diagnosis of diabetes.
        - The Department may choose to implement subsequent required disease management programs any time after the initial year of the health home program. Based on population-specific disease burdens, individual Health Homes may choose to identify and operate additional disease management programs at any time.
    - Complete web-based member enrollment, disenrollment, members' consent to release to information, and health risk questionnaires for all members
    - Each Health Home shall implement a formal screening tool to assess behavioral health (mental health and substance abuse) treatment needs along with physical health care needs.
- Enhanced Access
    - Provide for 24/7 access to the care team that includes, but is not limited to, a phone triage system with appropriate scheduling during and after regular business hours to avoid unnecessary emergency room visits and hospitalizations.
    - Monitor access outcomes such as the average 3rd next available appointment and same day scheduling availability.
    - Use of email, text messaging, patient portals and other technology as available to the practice to communicate with patients is encouraged.

Health Homes Service Delivery Systems

Provide a summary of the contract language for the additional requirements:
The Lead Entities are contractually required to conduct the following chronic condition health home tasks:

- Develop a network of Health Homes which meet the requirements established in the State Plan
- Provide training, technical assistance, expertise and oversight to Health Homes
- Provide tools for Health Home Providers to assess and customize care coordination based on the physical/behavioral health risk level of the member

- Perform data analytics on personal, medical and pharmacy data to identify patterns of care, as well as track, and close gaps in care member level and program wide
- Provide outcomes tools and measurement protocols to assess Health Home concept effectiveness
- Provide a repository for member data including claims, laboratory and CCD data whenever possible
- Support providers to share data including CCD or other data from electronic medical records
- Develop and offer learning activities which will support providers of Health Homes services
- Provide performance incentives
- Identify and enroll members to Health Homes.
- Perform data analysis at the member level and program-wide to inform continuous quality improvement
- Reimburse providers according to a reimbursement methodology proposed by the Contractor and approved by the Agency
- Develop an incentive payment structure, for the Agency review and approval that rewards Health Homes for performance based on quality and outcomes

The Lead Entity shall ensure that the Health Homes are using all tools and analytics to develop and implement strategies to effectively coordinate the care of each member across systems.

Additionally, the Lead Entity is required to provide clinical and care coordination support to the Health Homes.

The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.

The State intends to include the Health Homes payments in the Health Plan capitation rate.

The State provides an assurance that at least annually, it will submit to the regional office as part of their capitated rate Actuarial certification a separate Health Homes section which outlines the following:

- **Any program changes based on the inclusion of Health Homes services in the health plan benefits**
- **Estimates of, or actual (base) costs to provide Health Homes services (including detailed a description of the data used for the cost estimates)**
- **Assumptions on the expected utilization of Health Homes services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)**

- **Any risk adjustments made by plan that may be different than overall risk adjustments**
- **How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM**

The State provides assurance that it will design a reporting system/mechanism to monitor the use of Health Homes services by the plan ensuring appropriate documentation of use of services.

The State provides assurance that it will complete an annual assessment to determine if the payments delivered were sufficient to cover the costs to deliver the Health Homes services and provide for adjustments in the rates to compensate for any differences found.

Health Homes Payment Methodologies

FFS

Per Member, Per Month Rates

Provide a comprehensive description of the rate setting policies the State will use to establish Health Homes provider reimbursement fee-for-service or PMPM rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

The PMPM payment is a reflection of the added value provided to members receiving this level of care and will be risk-adjusted based on the level of acuity assigned to each patient with no distinction between public or private health home providers. The Health Home provider will tier the eligible members into one of four tiers with a PMPM payment assigned to each tier.

Tier	Minutes Per Month	Sum of Chronic Conditions
1	15	1-3
2	30	4-6
3	60	7-9
4	90	10+

Additional Tiering Information
Qualifying members as described in the Population Criteria Section of the document are automatically a Tier 1 member. To qualify for a higher tier, providers will use a State provided tier tool that looks at Expanded Diagnosis Clusters to score the number of conditions that are chronic, severe and requires a care team.

The PMPM payment is a reflection of the added value provided to members receiving this level of care and will be risk adjusted based on the level of acuity assigned to each patient with no distinction between public or private health home providers. The health home provider will tier the eligible members into one of four tiers with a PMPM payment assigned to each tier.

Patient Management Per Member Per Month Payment

This reimbursement model is designed to only pay for Health Home services as described in the six service definitions (Comprehensive Care Management, Care Coordination, Comprehensive Transitional Care, Health Promotion, Individual and Family Support, and Referral to Community and Social Services) may or may not require face-to-face interaction with a health home patient. However, when these duties do involve such interactions, they are not traditionally clinic treatment interactions that meet the requirements of currently available billing codes.

The criteria required to receive a monthly PMPM payment is:

- The member meets the eligibility requirements as identified by the provider and documented in the members electronic health record (EHR).
- Member's eligibility requirements verified within the last 12 months.
- The member has full Medicaid benefits at the time the PMPM payment is made.
- The member has agreed and enrolled with the designated health home provider.
- The Health Home provider is in good standing with IME and is operating in adherence with all Health Home Provider Standards.
- The minimum service required to merit a Patient Management PMPM payment is that the person has received care management monitoring for treatment gaps defined as Health Home Services in this State Plan. The Health Home must document Health Home services that were provided for the member.
    - The patient medical record will document health home service activity and the documentation will include either a specific entry, at least monthly, or an ongoing plan of activity, updated in real time and current at the time of PMPM attestation.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Health Home services. The agency's fee schedule rate was set as of July 1, 2020 and is effective for services provided on or after that date. All rates are published at https://dhs.iowa.gov/ime/providers/csrp/fee-schedule

The Health Home will bill a S0280 with the appropriate modifier to identify the tier with the informational codes on subsequent line items to attest to Health Home Services Provided.

Tier	Modifier	Health Home Service	Code
1 (1-3 CC)	U1	Chronic Care Management	G0506
2 (4-6 CC)	TF	Care Coordination	G9008
3 (7-9 CC)	U2	Health Promotion	G2058
4 (+10 CC)	TG	Comprehensive Transitional Care	G2065

		Individual &Family Support Services	H0038
		Referral to Community and Social Support Services	S0281

Risk Based Managed Care (description included in Service Delivery section)
Same as FFS

Explain how the State will ensure non-duplication of payment for similar services that are offered through another method, such as1915(c) waivers or targeted case management.

In order to avoid duplication of services, members currently receiving Community-Based Case Management (CBCM) as a Home and Community Based Waiver Service, or service coordination from a DHS Case Manager will have the delivery of this care coordinated between the entities. Additionally, Lead Entities are contractually required to ensure non-duplication of payment for similar services; the State reviews and approves Lead Entity non-duplication strategies and conducts ongoing monitoring to assure continued compliance.

If the individual is already enrolled in an Integrated Health Home (IHH) for members with a Serious Mental illness or Serious Emotional Disturbance, the member must choose between the Chronic Condition Health Home (CCHH) and the IHH. A member cannot be in more than one Health Home at the same time. Members in the Health Home will have state plan services coordinated through the Chronic Condition Health Home Provider.

Health Homes Services

Comprehensive Care Management

Comprehensive care management is the initial and ongoing assessment and care management services aimed at the integration of primary, behavioral and specialty healthcare, and community support services, using comprehensive person-centered care plan that addresses all clinical and non-clinical needs and promotes wellness and management of chronic conditions in pursuit of optimal health outcomes.

Definition:

Managing the Comprehensive Care for each member enrolled in the health home includes at a minimum:

- Outreach and engagement activities to members to gather information and engage in comprehensive care management
- Assessment of the member's current and historical information provided by the member, the Lead Entity, and other health care providers that supports the member

- Assessment includes a physical and behavioral assessment, medication reconciliation, functional limitations, appropriate screenings, completed by a licensed health care professional within 30 days of enrolling
- Assess the member's social environment so that the plan of care incorporates areas of needs, strengths, preferences, and risk factors
- Assessing member's readiness for self-management using screenings and assessments with standardized tools
- Assess the member's physical and social environment ensuring that the plan of care incorporates areas of needs, strengths, preferences, and risk factors
- Assessment is conducted at least every 12 months or more frequently as needed when the member's needs or circumstances change significantly or at the request of the member or member's support
- Creation of a person-centered care plans by a licensed health care professional with the member and individuals chosen by the member that address the needs of the whole person with input from the interdisciplinary team and other key providers Organize, authorize and administer joint treatment planning with local providers, members, families and other social supports to address total health needs of members
- Wraparound planning process: identification, development and implementation of strengths-based individualized person-centered care plans addressing the needs of the whole child and family
- At least monthly reporting of member gaps in care and predicted risks based on medical and behavioral claims data matched to Standard of Care Guidelines
- Serve as communication hub facilitating the timely sharing of information across providers 24 hours/day, 7 days/week
- Serve as active team member, monitoring and intervening on progress of member treatment goals using holistic clinical expertise
- Assignment of team roles and responsibilities
- Developing and maintaining a Continuity of Care Document (CCD) for all patients, detailing all important aspects of the patient's medical needs, treatment plan, and medication list.
- Implementing a formal screening tool to assess behavioral health (mental health and substance abuse) treatment needs along with physical health care needs.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:

By the provider maintaining an electronic system with standards/protocols for tracking patient referrals, and using the Health Information Network (HIN) to exchange health records, comprehensive care management can be more easily achieved.
Providers shall establish an electronic system (as part of their EHR system) that supports evidenced-based decisions.

The Lead Entity will provide technology support for comprehensive care management. MCO technology support functions are reviewed and approved by the State. Examples

of technology support functions which may be employed by Lead Entities, subject to State review and approval include, but are not limited to the following:

- A secure portal with program and member level information
- An enrollment feature with status and authorization release forms
- Predictive modeling and reporting tool to identify the population at risk including risks for hospital admission, gaps in care, and other claims based data
- Assessment-driven whole person member profile development provided to inform local IHH provider
- Administration of online provider tools, including Health and Wellness Questionnaire to assess initial risk level, and Care Coordination Plan
- Member profile summarizing key information about the members medications, healthcare services, recent claims, and gaps in care
- Ability to exchange and display continuity of care documents sourced from providers' electronic health records to facilitate timely sharing of clinical information among treating providers
- A data warehouse for ongoing monitoring and analysis of program activity, provider engagement, and outcomes
- Regular report distribution to the local CCHH Provider teams
- A member website

The benefit/service can only be provided by certain provider types.

Comprehensive Care Management services are the responsibility of the Designated Practitioner role within the Health Home. The Nurse Care Coordinator can assist with comprehensive care management.

Care Coordination

Definition:

Care Coordination includes assisting members with medication adherence, appointments, referral scheduling, understanding health insurance coverage, reminders, and transition of care, wellness education, health support and/or lifestyle modification, and behavior changes. Coordinate, direct, and ensure results are communicated back to the health home.

- Implementation of a Person-Centered Care Plan
- Outreach activities to members to engage in care coordination
- Continuous monitoring of progress towards goals identified in the person-centered care plan though face-to-face and collateral contacts with member, member’s supports, primary care, and specialty care. Scheduling appointments
- Making referrals
- Tracking referrals and appointments

- Follow-up monitoring
- Communicating with providers on interventions/goals
- Addressing barriers to treatment plan
- Appropriately arrange care with other qualified professionals for all the patient's health care needs. This includes care for all stages of life, acute care, chronic care, preventive services, long-term care, and end of life care

The use of HIT is the recommended means of facilitating these processes that include the following components of care:

- Mental health/ behavioral health
- Oral health
- Long-term care
- Chronic disease management
- Recovery services and social health services available in the community
- Behavior modification interventions aimed at supporting health management (e.g., obesity counseling and tobacco cessation, health coaching)
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up

When the member receives care coordination from a TCM, CM, or Service Coordinator, the Health Home must collaborate with TCM, CM, and Service Coordinators to ensure the care plan is complete and not duplicative between the two entities.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:

The establishment of an EHR system will assist care coordinators with maintaining a comprehensive medication list, allow providers access to evidenced-based decisions and assist with referral protocols.
Health IT can assist care coordinators providing and disseminating wellness education, informative tracks, and resources that supports lifestyle modification and behavior changes.
The Lead Entity will provide a secure portal to assist the IHH to coordinate care.

The benefit/service can only be provided by certain provider types.

The Care Coordinator role is responsible for ensuring these services are performed with The assistance of the entire the Health Home team.

Health Promotion

Definition:

Health Promotion includes coordinating or providing behavior modification interventions aimed at supporting health management, improving disease outcomes, disease prevention, safety and an overall healthy lifestyle.

Use of Clinical Decision Support within the practice workflow.
Implementation of a formal Diabetes Disease Management Program.

- Promoting members' health and ensuring that all personal health goals are included in person-centered care management plans
- Promotion of substance abuse prevention, smoking prevention and cessation, nutritional counseling, obesity reduction, and increased physical activity
- Providing health education to members and family members about preventing and managing chronic conditions using evidence-based sources
- Provide prevention education to members and family members about health screening, childhood developmental assessments and immunization standards
- Providing self-management support and development of self-management plans and/or relapse prevention plans so that members can attain personal health goals
- Using motivational interviewing and other evidenced based practices to engage and help the member in participating and managing their own care
- Promoting self-direction and skill development in the area of independent administering of medication and medication adherence
- Provide prevention education to members and family members about health screening, childhood developmental assessments and immunization standards
- Increasing health literacy and self-management skills
- Education or training in self-management of chronic diseases

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:

The establishment of an EHR system will assist care coordinators with maintaining a comprehensive medication list, allow providers access to evidenced-based decisions and assist with referral protocols.
Health IT can assist care coordinators providing and disseminating wellness education, informative tracks, and resources that supports lifestyle modification and behavior changes.

The benefit/service can only be provided by certain provider types.

Health Promotion services are the responsibility of the Nurse Care Coordinator with the assistance of the entire team.

Comprehensive transitional care from inpatient to other settings, including appropriate follow-up

Comprehensive transitional care is the facilitation of services for the individual and supports when the member is transitioning between levels of care (nursing facility, hospital, rehabilitation facility, community based group home, family, or self-care, another Health Home).

Definition:

- Develop relationships with hospitals and other institutions and community providers to ensure efficient and effective care transitions
- Provide prompt notification communication of member's admission/ discharge to and from an emergency department, inpatient residential, rehabilitative or other treatment settings
- Active participation in discharge planning to ensure consistency in meeting the goals of the member's person-centered plan
- Communicating and providing education the member, supports, where the member is located and where the member is transitioning
- Ensure the following:
  - Receipt of updated information through a CCD.
  - Receipt of information needed to update the patient's care plan (could be included in the CCD) that includes short-term transitional care coordination needs and long-term care coordination needs resulting from the transition.
  - Medication reconciliation
  - Reevaluation of the care plan to include and provide access to needed community supports that includes short-term and long term care coordination needs resulting from the transition
  - Plan to ensure timely scheduled appointments
- Facilitate transfer from a pediatric to an adult system of health care

The Designated Provider shall establish personal contact with the patient regarding all needed follow-up after the transition.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:

The establishment of an EHR system will assist care coordinators with maintaining a comprehensive medication list, allow providers access to evidenced-based decisions and assist with referral protocols.

Health IT can assist care coordinators providing wellness education and information that supports lifestyle modification and behavior changes.

The benefit/service can only be provided by certain provider types.

Comprehensive Transitional Care services are the responsibility of the Dedicated Care Coordinator role and Designated Practitioner role within the Health Home with the assistance of the Health Coach.

Individual and family support, which includes authorized representatives

Individual and Family Support Services include communication with patient, family and caregivers to maintain and promote the quality of life with particular focus on community living options. Support will be provided in culturally appropriate manner for the purposes of assessment of care decisions, including the identification of authorized representatives.

Definition:

Individual and Family Support Services include communication with patient, family and caregivers in culturally appropriate manner for the purposes of assessment of care decisions, including the identification of authorized representatives.

Activities could include but are not limited to:

- Advocating for individuals and families,
- Assisting with obtaining and adhering to medications and other prescribed treatments.
- Increasing health literacy and self-management skills
- Education regarding concerns applicable to the member
- Education or training in self-management of chronic diseases
- Assess the member's physical and social environment so that the plan of care incorporates areas of needs, strengths, preferences, and risk factors.

When the member receives care coordination from a Community-Based Case Management as a Home and Community-Based Waiver Service or Service Coordinator, the Health Home must collaborate with Community-Based Case Management as a Home and Community-Based Waiver Service and Service Coordinators to ensure the care plan is complete and not duplicative between the two entities.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:

Health IT can assist care coordinators providing information that is culturally and linguistically appropriate for the patient, family and caregivers.

The benefit/service can only be provided by certain provider types.

Individual and Family Support services are the responsibility of the Health Coach role within the health home.

Referral to community and social support services, if relevant

Referral to Community and Social Support Services includes coordinating or providing recovery services and social health services available in the community, such as understanding eligibility for various healthcare programs, disability benefits, and identifying housing programs.

Definition:

Referral to Community and Social Support Services includes coordinating or providing recovery services and social health services available in the community, such as understanding eligibility for various healthcare programs, disability benefits, and identifying housing programs.

When the member receives care coordination from a Community-Based Case Management as a Home and Community-Based Waiver Service or Service Coordinator, the Health Home must collaborate with Community-Based Case Management as a Home and Community-Based Waiver Service and Service Coordinators to ensure the care plan is complete and not duplicative between the two entities.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:

By maintaining an electronic system with standards/protocols for tracking patient referrals, and using health IT to exchange health records, comprehensive care management can be more easily achieved.

The care coordination plan will be used to plan and manage referrals for community and social support services. Evidence-based care guidelines are also provided for use by Health Home teams and providers.

The benefit/service can only be provided by certain provider types.

Referral to Community and Social Support services are the responsibility of the Dedicated Care Coordinator role within the health home with the assistance of the Health Coach.

Health Homes Monitoring, Quality Measurement and Evaluation

Describe the State's methodology for tracking avoidable hospital readmissions, including data sources and measurement specifications:

The State will utilize Medicaid claims and encounter data to assess the difference in incidence rates of 30-day All-cause “Unplanned” Hospital Readmission events between enrolled Health Home members and non-enrolled members. Readmission outcomes

exclude “planned” hospitalizations within 30 days of an initial “anchor” hospitalization and “transfer” hospitalizations on the same day of an initial “anchor” hospitalization using institutional claims’ patient status codes (discharge codes) and admission/discharge dates. Inferential methods utilize a cross-sectional case/control cohort quasi-experimental design.

Propensity scoring, matching, and/or predictive cost models will be used to identify non-enrolled members (Control cohort) that are similarly matched to enrolled Health Home members (Treatment/Case cohort) in regards to baseline age, gender, predicted expenditures, and multiple chronic/acute condition characteristics. Cohorts are then assessed for differences in outcomes during a specified evaluation period (annual) via doubly robust count-based multivariate regression techniques. Count-based regression models risk adjust final estimates of differences in readmission outcomes through the reuse of select matching covariates (age, gender), additional covariates (county of residence, long-term service support status), and members’ varying time spans of Medicaid enrollment. These methods are used to carry out analyses for each Tier.

Describe the State's methodology for calculating cost savings that result from improved coordination of care and chronic disease management achieved through the Health Home program, including data sources and measurement specifications.

The State will utilize Medicaid claims and encounter data to assess the difference in average per-member-per-month (PMPM) expenditures (final paid claim allowed amounts) between enrolled Health Home members and non-enrolled members. Inferential methods utilize a longitudinal case/control cohort quasi-experimental design. Propensity scoring, matching, and/or predictive cost models will be used to identify non-enrolled members (Control cohort) that are similarly matched to enrolled Health Home members (Treatment/Case cohort) in regards to baseline age, gender, predicted expenditures, and multiple chronic/acute condition characteristics. Cohorts are then assessed for differences in expenditure outcomes during a specified evaluation period (annual) via doubly robust multivariate linear regression techniques. Regression models include the reuse of select matching covariates (age, gender), additional covariates (time, county of residence, long-term service support status), and adjustment for correlated member-specific expenditure measurements over time (adjust for clustering of repeated measures) to yield risk-adjusted estimates of differences in expenditure outcomes.

Regression models include an interaction term of time and treatment cohort to evaluate the difference in trends of expenditures between cohorts over time. Sensitivity analyses are conducted to explore the impact on measurements after removal of matched cohort members with high-cost severe/acute conditions and where removal of high-cost leverage/outlier situations may be prudent. These methods are used to carry out analyses for each Tier.

Describe how the State will use health information technology in providing Health Home services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

The Lead Entity will provide technology infrastructure for health information exchange to be utilized by the Health Homes in order to facilitate collaboration. These capabilities include, but are not limited to; patient screening and risk stratification, and a web-based profile that integrates Medicaid claims, patient self-reported information, and clinical documentation. The Lead Entity will be responsible for sharing health utilization and claims data with the Health Homes to facilitate care coordination and prescription monitoring for members receiving Health Home services. A member website will be available to Health Home enrollees, their families, and supports. It will contain evidence-based information on conditions, health promotion and wellness information, and links to resources.

As a part of the minimum requirements of an eligible provider to operate as a health Home, the following relate to HIT:

- Demonstrate use of a population management tool (patient registry) and the ability to evaluate results and implement interventions that improve outcomes over time.
- Demonstrate evidence of acquisition, instillation and adoption of an EHR, system and establish a plan to meaningfully use health information in accordance with federal law.
- Provider for 24/7 access to the care team that includes but is not limited to a phone triage system with appropriate scheduling during and after regular business hours to avoid unnecessary emergency room visits and hospitalizations.
- Encourage providers to utilize email, text, messaging, patient portals and other technology as available to communicate with providers.

Describe how the State will collect information from the Health Homes providers for purposes of determining the effect of the program on reducing the following:

Hospital Admission Rates
Measure Specification, including a description of the numerator and denominator.
The State will consolidate data from Medicaid claims and encounter data and monitor the difference in incidence rates and length of stay between enrolled Health Home Members and like non-enrolled members. (Measure calculations may be impacted by Medicare data availability)
Data Sources: Claims, including MCO encounter data
Annually

ER Visit
Measure Specification, including a description of the numerator and denominator.

The State will consolidate data from Medicaid claims and encounter data and monitor the difference in incidence rates between enrolled Health Home Members and like non-enrolled members. (Measure calculations may be impacted by Medicare data availability)
Data Sources: Claims, including MCO encounter data
Annually

SNF Admissions
Measure Specification, including a description of the numerator and denominator.
The State will consolidate data from Medicaid claims and encounter data and monitor the difference in incidence rates and length of stay between enrolled Health Home Members and like non-enrolled members. (Measure calculations may be impacted by Medicare data availability)
Data Sources: Claims, including MCO encounter data
Annually

Describe how the State will collect information for purpose of informing the evaluations, which will ultimately determine the nature, extent and use of the program, as it pertains to the following:

Hospital Admission Rates
The State will consolidate data from Medicaid claims and encounter data and monitor the difference in incidence rates and length of stay between enrolled Health Home Members and like non-enrolled members. (Measure calculations may be impacted by Medicare data availability)

Chronic Disease Management
Clinical data received from providers on Health Home enrollees will provide the best picture for this evaluation.

Coordination of Care for Individuals with Chronic Conditions
Clinical data received from providers on health home enrollees will provide the best picture for this evaluation.

Assessment of Program Implementation
This will consist of a review of the program administrative costs, reported patient outcomes, and overall program cost savings and patient surveys.
An evaluation that details the process of implementation, as well as the challenges experienced and adaptations that were made during the implementation will be undertaken.

Lead Entity Dashboard
The Lead Entity will have a withhold that can be earned back through meeting identified benchmarks.

Priority	Measure
Structure	Lead Entity Self-Assessment

	Health Home Self-Assessment
Process	Health Home Dashboard
	A15 Report
	CSR Report
	Level of Care Report
Outcomes	Member Surveys
	Performance Measures
	CMS Health Home Core Measures
	Chart Review Results

Health Home Dashboard
The Health Home will have practice transformation assistance by the Lead Entities based on the Health Home Dashboard.

Priority	Measure
Structure	Health Home Self-Assessment
Process	Health Home Dashboard
Outcomes	Member Surveys
	Performance Measures
	CMS Health Home Core Measures
	Chart Review Results

Processes and Lessons Learned
An evaluation that includes provider and patient input on the Health Home Program will inform the state on ways to improve the process.
The State Medicaid Agency and the Lead Entity will continue to develop tools to capture feedback from the Health Homes to document and understand any operational barriers to implementing Health Home Services.
As more successful Health Homes are identified via clinical data and claims data, implementation guidelines and suggestions will be documented and trained to further promote success statewide.

Assessment of Quality Improvements and Clinical Outcomes
An evaluation that includes provider and patient input on the Health Home Program will inform the state on ways to improve the process.
An evaluation of clinical data shared by providers will allow the state to adjust the clinical outcome measures to ensure the optimal results and continued improvement.

Cost Savings
The State will utilize Medicaid claims and encounter data to assess the difference in average per-member-per-month (PMPM) expenditures (final paid claim allowed amounts) between enrolled Health Home members and non-enrolled members. Inferential methods utilize a longitudinal case/control cohort quasi-experimental design. Propensity scoring, matching, and/or predictive cost models will be used to identify non-

enrolled members (Control cohort) that are similarly matched to enrolled Health Home members (Treatment/Case cohort) in regards to baseline age, gender, predicted expenditures, and multiple chronic/acute condition characteristics. Cohorts are then assessed for differences in expenditure outcomes during a specified evaluation period (annual) via doubly robust multivariate linear regression techniques.

Regression models include the reuse of select matching covariates (age, gender), additional covariates (time, county of residence, long-term service support status), and adjustment for correlated member-specific expenditure measurements over time (adjust for clustering of repeated measures) to yield risk-adjusted estimates of differences in expenditure outcomes. Regression models include an interaction term of time and treatment cohort to evaluate the difference in trends of expenditures between cohorts over time. Sensitivity analyses are conducted to explore the impact on measurements after removal of matched cohort members with high-cost severe/acute conditions and where removal of high-cost leverage/outlier situations may be prudent.